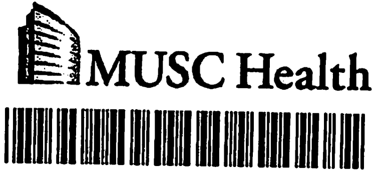

AUTHRELSE

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

This form must be completed in its entirety in order to be considered valid.

Patient Name: ____________________ Date of Birth: ____________________

Medical Record Number: ____________________ Last 4 digits Social Security Number: __________

☒ I authorize MUSC Medical Center to disclose / release information to:
☐ I authorize MUSC Medical Center to obtain information from:

Name of Individual / Organization: Donnie Gamache, Attorney at Law

Street Address: P.O. Box 550 City: Summerville State: SC Zip Code: 29484

Phone Number: 843-821-8280 Fax Number: 888-492-8289 E-mail Address: clients@gamachelawfirm.com

The purpose of the disclosure is: ☐ Continued care ☐ Legal ☐ Insurance ☐ Disability ☐ Patient Request
☐ Other ____________________ **Date(s) of service:** __________

☐ An **"abstract"** of the medical record is provided as the first level of release of information (comprehensive overview of entire record). This includes: history and physical, consults, lab and radiology reports, discharge summary, operative / procedure reports, Emergency Department reports, Occupational Therapy / Physical Therapy reports.

In addition to the "abstract" information, the following information may be requested:

☐ Films / images	☐ Immunization records	☐ Medication list	☐ Physician progress / visit notes
☐ Physician orders	☐ Nurses notes	☐ Entire record	☐ Other:

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS and / or alcohol abuse.

I authorize the exchange of this information via (check all preferred methods): ☐ mail ☐ fax ☐ e-mail ☐ other ______

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked, this authorization will expire / end one year from this date or ____________________.

I understand that fees for copies of medical records and postage fees may be charged.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information. I understand I will be given a copy of this authorization.

A copy of my identification will be made and attached to this authorization.

____________________ ____________________
Signature of Patient or Legal Guardian / Representative Date

____
Printed Name of Patient or Legal Guardian / Representative

____________________ ____________________
Relationship to Patient, if signed by Legal Guardian / Representative Witness Signature

Description of patient representative's authority: ____________________
(The reason the patient is not signing)

To contact Health Information Services (Medical Records) in writing, the address is: 169 Ashley Avenue / MSC 349 / Attention: Release of Information / Charleston, South Carolina 29425-3490; the phone number is (843) 792-3881.